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THE VALUE OF MOBILITY INSTRUCTION AS A TECHNIQUE TO MOTIVATE BLIND INDIVIDUALS.

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A 3-YEAR DEMONSTRATION PROJECT WAS DESIGNED TO PROVIDE THE BLIND WITH MOBILITY INSTRUCTION, TO SHOW AGENCIES AND COMMUNITIES THE NEED FOR SUCH INSTRUCTION, AND TO OBTAIN INFORMATION ABOUT MOTIVATION AND MOBILITY. OF THE 73 BLIND PERSONS IN MECKLENBURG COUNTY (NORTH CAROLINA) WHO INQUIRED BY INDIVIDUAL APPLICATION OR WERE REFERRED BY OTHER AGENCIES, 14 MALES AND 17 FEMALES, AGED 14 TO 70 YEARS, PARTICIPATED IN THE MOBILITY TRAINING. FOLLOWING INTERVIEWS WITH THE CASEWORKER AND THE PERIPATOLOGIST, THE SUBJECTS WERE EXAMINED BY AN OPTHALMOLOGIST TO DETERMINE PRESENCE OF RESIDUAL VISION, A PHYSICIAN TO DETERMINE PHYSICAL CAPACITY, AND AN AUDIOLOGIST TO DETERMINE ABILITY TO HEAR AND TO DISCRIMINATE AMONG SOUNDS. AFTER AN INTERPRETIVE INTERVIEW EXPLAINING THE COURSE OF INSTRUCTION, THE SUBJECTS BEGAN TRAINING. THE SUBJECTS RECEIVED AN AVERAGE OF 22 INDIVIDUAL HOUR TRAINING LESSONS. AT TERMINATION OF THE LESSONS, 18 SUBJECTS COULD TRAVEL INDEPENDENTLY IN RESIDENTIAL AREAS (SEVEN OF THESE COULD TRAVEL IN BUSINESS AREAS ALSO). SUCCESS IN MOBILITY APPARENTLY ENHANCED MOTIVATION TO IMPROVE IN OTHER AREAS OF SOCIAL FUNCTIONING. MOST CLIENTS FELT THAT DAILY LESSONS WERE MORE ADVANTAGEOUS THAN LONGEF LESSONS ON ALTERNATIVE DAYS. ABOUT 75 PERCENT OF THE CLIENTS WERE SATISFIED WITH THE LONG EVALUATION PROCESS WHICH PRECEDED THE BEGINNING OF INSTRUCTION. OVER HALF OF THE CLIENTS WHO INQUIRED DID NOT TAKE MOBILITY TRAINING FOR VARIOUS REASONS, INCLUDING REJECTION DUE TO MEDICAL CONDITIONS, LACK OF INTEREST, FAMILY OBJECTIONS, RESIGNATION OF INSTRUCTOR, OR EMOTIONAL STATE. (KH)

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Mecklenburg Association for the Blind
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THE VALUE OF MOBILITY INSTRUCTION AS A TECHNIQUE TO MOTIVATE BLIND INDIVIDUALS

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With a foreword

by

Lee A. Burke, President

Board of Directors

Mecklenburg Association for the Blind

A demonstration conducted by the Mecklenburg Association for the Blind, 704 Louise Avenue, Charlotte, North Carolina, and supported, in part, by a demonstration grant, #1169, from the Vocational Rehabilitation Administration, Department of Health, Education and Welfare, Washington, D. C. 20201

August, 1966

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The Advisory Committee, composed of leaders in the Field of Work for the Blind, contributed professional guidance needed for such a mobility project and were at all times available for consultation as the project progressed.

A special word of thanks is recorded to the ophthalmologists in this area for their help with the project.

The Board and the staff of the Mecklenburg Association for the Blind are to be commended for their infinite patience and understanding and for creating an atmosphere in which this project could unfold.

And lastly, we wish to express gratitude to Arthur M. Dye, Jr., whose determined interest and dedication to the Field was responsible for getting the project started.

Mecklenburg Association for the Blind
July 1, 1966

Ralph J. McCoig

FOREWORD

Following the Study of "Services for Blind Persons in Mecklenburg County, North Carolina" sponsored by the Social Planning Council of United Community Services in Charlotte, North Carolina, and conducted by the Division of Community Services of the American Foundation for the Blind in February, 1962, the Mecklenburg Association for the Blind Board and staff became acutely aware of the need for mobility services in this area. In addition, the Association was in the midst of a transitional stage which involved the professionalization of services to be rendered to the clientele. Therefore, all efforts at this time were focused on beginning a mobility program of a professional nature.

After much detailed study and consideration by the staff and the Board of the Association, a proposal was submitted to the Office of Vocational Rehabilitation, Department of Health, Education and Welfare, Washington, D. C., to conduct a mobility project at the Mecklenburg Association for the Blind under a demonstration grant. As set forth in this proposal, the primary objectives were to:

1. Provide mobility training to as many people as possible;
2. gather information about the mobility and motivation;
3. to demonstrate to the community the need for mobility services.

The report which follows is an account of the progress of this mobility project during the three years period from June, 1963, to July, 1966. This project is considered by the Board of Directors as being that of the pioneering effort,

and the value of the project is reflected in the total knowledge gained.

The Vocational Rehabilitation Administration, Department of Health, Education and Welfare, is to be commended for sponsoring this project. The lack of mobility training in a nonresidential setting has long been evident. Hopefully, this report will contribute to the field a better understanding of the dynamics involved.

Lee A. Burke, President
Mecklenburg Association for the Blind

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CHAPTER I

INTRODUCTION

> "The immobilized blind person is fixed, rooted, confined to the spot on which he stands. He is without security, without maturity, without ability, a terribly dependent being."

These words by Rev. Thomas J. Carroll exemplified the thinking of the Mecklenburg Association for the Blind (hereafter referred to as MAB) staff during the early part of 1962, and gave impetus to the formulation of plans to determine the need of mobility training on a nonresidential basis in the Charlotte, North Carolina, area.

In February, 1962, the results were released of the Study of Services for Blind Persons in Mecklenburg County, North Carolina, sponsored by the Social Planning Council of United Community Services, Charlotte, North Carolina, and conducted by the Division of Community Services of the American Foundation for the Blind. Regarding mobility, the Study stated that, "Mobility training is a type of training which teaches a blind person the proper use of a cane and the technique of using it in conjunction with his other senses to get from place to place. Such training is essential for blind persons who cannot move about independently. In Mecklenburg County it is impossible for a blind person to learn even the rudiments of using a cane properly. With a known population of nearly six hundred (600) persons, most of whom have not had mobility training, it would appear that the employment

of such a worker is fully justified and highly desirable. Therefore, the recommendation was that the MAB should employ a fully qualified mobility instructor without delay."

With this professional recommendation, the MAB Board of Directors and Staff began exploring ways of implementing this recommendation. After much serious consideration, an initial plan was prepared which was entitled, "Peripatology Proposal," which proposed to set up a summer program to gain experience with the mobility program. This proposal was discussed with many leaders in the Field of Work for the Blind, and it was not felt by most that this would be a workable solution to the implementation of mobility in the Charlotte area primarily because of two reasons. One would be the extreme difficulty in hiring a mobility instructor for such a short period of time; and, two, was the idea that a summer program could not really provide a great deal of experience because of the time limitation.

Adhering to the advice of those persons consulted, the MAB drew up a proposal and submitted it to the Office of Vocational Rehabilitation Administration for approval. The title of this proposal was, "The Value of Mobility Training as a Tool or Technique to Motivate Blind Individuals." In November, 1962, this proposal was approved by the Office of Vocational Rehabilitation Administration as a selected demonstration project. The MAB then began earnestly recruiting for a professional mobility instructor to begin the program. The project was delayed because a qualified instructor could not be found. In June of 1963 a professional mobility instructor was hired and the program got under way.

Until June of 1963, mobility training opportunities in the Southeastern area were extremely lacking. The selected demonstration grant awarded the MAB was the first such grant awarded, enabling an agency in the Southeastern area to provide professional mobility training. This project was designed with three basic purposes in mind:

1. To provide the best possible mobility instruction to as many people as possible.
2. To gather information concerning motivation and mobility.
3. To demonstrate to other agencies and communities the need for this instruction.

Hopefully, through the pioneering effort of MAB, the value and necessity for a professional mobility training program for blind people would be recognized and encourage other agencies in the Southeastern area to implement similar programs. Several agencies throughout the Southeastern area are now providing mobility programs on a non-residential basis.

Using the 1963 Study of Services as a base, the need for professional mobility instruction was enforced by a review of the literature of other leaders in the Field of Work for the Blind. The writings of many authorities were considered. George Kertin, Supervisor of Individual Services of the Massachusetts Division of the Blind, states, "Mobility is more than safe, gracious, physical movement; it is a psychological movement involving attitudes, ideas, aspirations, and ambitions." Irving Kruger of the New Jersey State Commission for the Blind believes that, "Immobility is a breeder of stagnation, whether it be physical

or mental." In 1960, the Research Center of the New York School of Social Work prepared a Study called, "The Demand for Dog Guides and the Travel Adjustment of Blind Persons." Among the findings were the following: 1. Most blind persons are dissatisfied with their travel performance. 2. This dissatisfaction is largely unaccompanied by active plans for improvement.

Through this research and by perusing other available literature regarding mobility training, it became evident that the lack of the ability or capacity for independent travel is a severely limiting factor which tends to increase dependency in other areas of life.

Mecklenburg County, North Carolina, is a community of three hundred thousand (300,000) which has many services for blind people. Within this community is a district office of the North Carolina State Commission for the Blind, a Workshop for the Blind, a program for blind children in the Department of Special Education of the Charlotte-Mecklenburg School System, and the MAB, a voluntary agency. The North Carolina State Commission for the Blind has on its staff, locally, two caseworkers who administer Aid to the Blind, a Rehabilitation Counsellor, and a Supervisor of stand operation. The program for blind children began several years ago and is the first integrated program for blind children in North Carolina. The Workshop for the Blind, a sheltered workshop which is nonprofit, employs approximately thirty-five (35) to forty (40) blind persons. The MAB as a voluntary agency was established with the primary purpose of helping blind persons to help themselves. The major services provided by the Association are counselling, hometeaching, child evaluation services, school placement and

mobility training. In addition, a very stable volunteer program is carried on to provide textbooks and tape recordings for the blind children who attend the classes in the public schools.

Along with these agencies who work directly with blind persons, there are approximately one hundred and thirty (130) voluntary and tax supported organizations serving all the citizens of Charlotte and Mecklenburg County. Of these, approximately forty-three (43) are members of the United Community Services. The MAB maintains a very close working relationship with many of these agencies and while the majority of referrals to the MAB comes from those agencies who work directly with blind people, some referrals come from other agencies. When indicated, the MAB refers blind clients to those agencies that provide the desired service.

CHAPTER II

THE MOBILITY PROGRAM AND PROCEDURES

In addition to Charlotte, Mecklenburg County encompasses the seven towns of Cornelius, Davidson, Huntersville, Matthews, Newell, Paw Creek, and Pineville.

There were five hundred and eighty-four (584) blind persons reported in the previous biennium in the County. They comprised 0.214% of the total 1960 population. This indicates a prevalence of 2.14 persons per thousand of population, and appears to be about .5 persons per thousand population below the average of the State of North Carolina as a whole.

The 1960 population figure for Mecklenburg County is two hundred and seventy-two thousand, one hundred and eleven (272,111) persons. However, Mecklenburg County has experienced a rapid population growth which is expected to continue unabated. The area has grown from one hundred and fifty-one thousand (151,000) persons in 1940 to one hundred and ninety-seven thousand (197,000) in 1950, and thence to the present figure. Population projections indicate an increase to four hundred-three thousand (403,000) in 1970, and to five hundred- twenty thousand (520,000) in 1980.

The techniques and procedures incorporated in the mobility training program at the MAB were those processes developed by Dr. Hoover and his colleagues and taught in the Graduate School of Boston College.

Eligibility for participation in the training project was open to any ambulatory person over sixteen (16) years of age whose visual difficulty was a serious impairment to independent travel and who did not have physical, psychological, or emotional problems which precluded the ability to participate in the training program. An upper age limit was not placed, but the physical condition of the older applicants was a limiting factor. In the beginning of the project there were many applicants which made it necessary for MAB to set up a waiting list. To present a good image and enhance acceptance of the program by future clients, the first people to be accepted were those considered to be the better adjusted individuals with good potential. However, the project was not limited to this type of person. It was found that persons with limited potential and adjustment could also derive benefits from mobility within their capabilities.

The team approach to rehabilitation was employed. The initial role of the mobility instructor was to interview the client and evaluate his needs for instruction. During this interview, the instructor attempted to gain some insight into why the individual desired instruction and what he expected to gain from the training program. The program was explained to the applicant and a record was made of his past mobility instruction and performance. When indicated, the instructor had the opportunity to work with the client for whatever number of sessions were needed to determine the best plan to meet the client's needs.

Applications for this training were accepted on the basis of referrals from other agencies and individual applications. The project caseworker served as intake worker and was responsible for collecting the diagnostic information. Involvement

of the caseworker with the client during the instruction period was helpful in interpreting the emotional status of the client. The caseworker was able to help the instructor by helping the client deal with changing feelings. The caseworker also had the responsibility for coordinating the team efforts in working with the client. The mobility instructor and other specialists involved made periodic reports to the team coordinator who incorporated this information in the case record.

It should be mentioned that the coordinating efforts were hampered by the absence of a caseworker who resigned just prior to the beginning of the project. Recruitment of a caseworker could not be accomplished until one year after the inception of the program.

The project director was an overall coordinator, responsible for the physical operation of the project. In addition, he was involved in the final evaluation of a potential client and during the first year of the project assumed the duties of the caseworker. This entailed, primarily, the obtaining of information concerning the client's motivational pattern and his reaction to mobility instruction. Other members of the project staff were the rehabilitation counsellor and caseworkers with the North Carolina State Commission for the Blind.

Applicants for the training program were referred from five main sources which were: Department of Public Welfare, North Carolina State Commission for the Blind, ophthalmologists, self referrals, and MAB case records. The evaluation process began with referral from one of the above mentioned sources. If this

referral came from the State Commission or Department of Public Welfare personnel, a brief summary of information was provided. If not, the MAB assumed the responsibility for obtaining all of the necessary information. The intake interview with the prospective client was conducted by the project staff caseworker who obtained a family history, general information regarding the client, and what his aspirations were as regards mobility.

Following the interview, the referral was given to the peripatologist who contacted the client and made arrangements for an interview to obtain information specifically concerned with mobility. The instructor attempted to gain information regarding previous mobility training instruction, the client's present need for mobility training, what the client specifically hoped to gain from mobility program, and evaluated the client's capacity for independent travel; from the standpoint of his attitude toward travel and present techniques employed by the potential client. The instructor explained in as much detail as needed the specifics of the mobility training program. After the diagnostic information was obtained, the instructor and caseworker conferred to gain a better understanding of the potential client and evaluated the material compiled to this point to see if there was need to recommend that the application be rejected. If there were no reasons for immediately ruling out the potential client for mobility training, the caseworker made the necessary arrangements to have him seen by an opthalmologist, a physician, and an audiologist. Frequently, this information was available through the referring source. The physical examination determined the client's physical capacity for participation in the

training program. If there were any physical limitations which did not preclude participation in the program, both the client and the instructor were aware of these and teaching plans were formulated to compensate for them.

The hearing examination was necessary to determine the potential client's ability to not only hear sounds but to discriminate between them. Mobility instruction can be carried out with varying degrees of hearing loss but to make the instruction more beneficial and to insure the safety of the client, it is necessary to know the degree and area of hearing loss. The ophthalmological examination was used to determine what, if any, residual vision existed and to obtain the ophthalmologist's recommendation about the client's potential utilization of any residual vision. The etiology of blindness and prognosis obtained from the ophthalmological report was helpful in understanding the client and in planning his program. When indicated, psychological examinations were administered to determine the type program best suited for the individual's needs. In some instances it was necessary to refer the applicant to other specialized agencies for additional information. For example, several clients were referred to the local Rehabilitation Hospital for an examination by a physical therapist to evaluate the individual's gait.

When all necessary information had been collected, the case was staffed by the project director, caseworker, and peripathologist. Personnel from the Department of Public Welfare or the North Carolina State Commission for the Blind were included when cases referred by them were staffed. All available information was presented with the recommendations and impressions of each

specialist. An interpretative interview was held with those clients accepted for mobility, and the instructor outlined a general plan of travel instruction to be followed.

Because the MAB was located in a residential area, the clients came there to train when the project first started. Clients coming to the agency gave the instructor more time to spend on training and it was felt that the techniques learned in the vicinity of the agency were adaptable to the client's own home environment. However, a good deal of the instructor's time was spent in traveling as the client progressed and needed instruction of a more complex nature in the business district. Initially, this plan was successful, but because clients frequently failed to keep appointments, it was necessary for the instructor to begin the training at the client's home. Obviously, more demands were made on the instructor's time because of the increased travel, but more clients could be served over a long period of time through this reaching out process.

In conjunction with the plan to facilitate serving a greater number of persons, the length of time of each lesson in the beginning of the project was of ninety (90) minutes duration. And, lessons were given on Monday, Wednesday, and Friday of the first week, and Tuesday and Thursday of the second week. As time went on, however, it was found that many clients had a problem of relating the past lesson to the present lesson because of the length of time between lessons. Consequently, the lesson plan was changed to a one hour period, five days each week.

The initial project plans called for casework services on the basis of once a week while the client was in training. It was felt by offering this service, the client's opportunity for success in mobility would be enhanced. The client had an opportunity to discuss his feelings regarding the program and other problems he found in dealing with his family or friends as a result of his new independence. With the resignation of the caseworker prior to the inauguration of the project, this plan was not followed for the first year, as the limited staff of the MAB was unable to provide this service. During the last two years of the project, casework services were offered on a once a week basis and were found to be effective. The caseworker assisted the instructor in planning future lessons by informing him of how much of the mobility training had been incorporated into the client's daily living activities. It was felt that the overwhelming stress experienced by some clients during the training was alleviated to a great degree by the support given by the caseworker. Often this support allowed them to continue with mobility training.

In the second year of the project, the program was expanded to include persons in nursing homes who were above the age of sixty-five (65) generally. It was recognized that many of these persons did not need the entire training program, but that it could help them in moving about independently within the environs of the nursing home. Administrators responsible for the operation of the various nursing homes in the Charlotte area were contacted and plans were made to use their resources for required medical and diagnostic information and to work out a suitable time to provide the mobility instruction. This expansion of the program

proved to be beneficial as for the first time since entering the nursing home many of the patients were taught to move about independently. It is also felt that it served as an educational process for the nursing home staff members. Since that time, many of them made referrals to the MAB. Also, some of their fears regarding admittance of blind persons into the nursing homes have been ameliorated.

CHAPTER III

COMMUNITY RELATIONSHIPS

Throughout the project, community education was carried on to make the community aware of the availability of mobility service at the MAB and what was involved in the program. At the outset all major communication media were employed. Many spot announcements were sent to the various radio stations for inclusion as part of their public service program. Local television stations filmed the demonstration of the technique and interviewed staff members of the MAB regarding this service. These programs were presented on several different occasions during prime time of news broadcasts. Both of the local newspapers interviewed the instructor and other MAB personnel and ran feature articles to help familiarize the general community with the mobility program. Publicity of this nature continued during the entire project but to a lesser degree.

In addition, community education was accomplished during the project through program presentations to civic groups, organizations of blind persons, student nurses, and other groups. Lions Clubs in Charlotte and Mecklenburg County were given demonstrations as it was felt they would be a good source of referral because of their vital interest in the Field of Work for the Blind. Although the educational means employed proved to be adequate, it is felt that more attention should have been given toward education of potential clients through increased radio coverage and group presentations.

Cooperation of the Department of Public Welfare and North Carolina State Commission for the Blind personnel was essential to the project. They served as members of the project staff and were responsible for interpreting the program to their clients and for making referrals. In addition, they were involved in staffings when a case referred by them was being considered. The overall working relationship was good as evidenced by the large number of referrals that were made for mobility training. Their attendance at all called meetings was good and the decisions made were influenced greatly by their contributions.

The MAB also maintained a cooperative relationship with other community agencies and used them as a resource when needed. For example, it was necessary to obtain psychological examinations of some clients and on several occasions the facilities of the Charlotte Rehabilitation Hospital were used to obtain a gait analysis. Local ophthalmologists referred some mobility clients directly and were responsible for self referrals by advising their patients of the program. Although the program was not interpreted to the ophthalmologists as a group, those who were members of Lions Clubs had an opportunity to see demonstrations. In addition, letters were written to all of them explaining the program and requesting referrals on a short referral form.

CHAPTER IV

DATA COLLECTION

Collection of data during this demonstration project was accomplished by use of case records and a schedule.

Contained in the case records are: rating scale, progress reports, social histories, medical information (includes audiological, opthalmoligical, and medical) and a final evaluative report. The rating scale and progress reports were completed by the Peripatologist and were used frequently as the training became more complex. Social history information was obtained by the case-worker and included identifying information and family history which was incorporated in the running dictation. In addition, medical information, a diagnostic tool, presented the overall health condition of the client and was sometimes useful in uncovering medical needs.

Upon completion of the individual's training program, the Peripatologist was responsible for writing up an evaluation of the client's travel performance and capability; recommending extent of future travel and needs.

One of the stated purposes of this project was to gather information regarding motivation and mobility. Some information was contained in the case record, but the need for additional information was evident. A schedule was designed by the project staff to help gather their information. The hypothesis formulated to develop the schedule was "Success in mobility enhances motivation to improve in other areas of social functioning." It was felt that increased independent

travel would have a direct bearing on the individual's total life situation and would help motivate the individual to improve in these areas.

With this idea in mind, several meetings were held with the entire project staff to discuss what should be included in the survey. They agreed that more valid responses would be obtained by the interviewer if open ended questions were utilized. If this approach did not elicit adequate information, then the interviewer was instructed to ask direct questions.

Copies of the proposed survey were forwarded to the Advisory Committee for their suggestions and/or modifications. The survey was favorably received and steps were taken to begin the interviewing. Role playing was done by the staff members of MAB to refine the schedule and interviewing techniques. An interview was held and other staff members commented on interviewing techniques and appropriateness of questions. Letters were sent to each client who had discussed mobility training during the three years period. This included those who had participated in the training program and also those who had just inquired about it. Two weeks after these letters were mailed, interviewing was begun by the peripatologist and caseworker. Immediately following the interview, the clients responses were recorded on the schedule to assure the inclusion of maximum information.

These were the two means utilized to collect data for this report and the tabulation of the results will appear in the following chapter.

CHAPTER V

OUTCOMES OF MOBILITY TRAINING

INTRODUCTION:

The results of the three year mobility program will be presented in the following manner:

1. Information obtained from case records will relate to:
   a. How many clients were served.
   b. Amount of training they received.
   c. Progress made during training program. Relevant information on those persons who inquired but did not take mobility training will also be discussed.
2. Survey: Material contained in the survey will, when pertinent, be presented to bring out significant points.

CLIENT POPULATION:

A total of seventy-three persons inquired about mobility training during the time that it was offered at the MAB. Of that number, thirty-one (31) participated in the training program. (See Master Table I.) The remaining forty-two (42) did not participate for several stated reasons. (See Master Table II.)

TABLE I

APPLICATIONS FOR MOBILITY TRAINING

Accepted	Rejected	Withdrew	Total
31	8	* 34	73

*Includes those applicants who had fewer than three interviews and did not continue intake process.

Of those who participated in the program, fourteen (14) were males, and seventeen (17) were females. The age range of females was seventeen (17) to seventy (70), with the average age being 37.5. The males showed an age range of fourteen (14) to sixty-six (66), and an average age of 38.9.

TABLE II

SEX AND AGE RANGE OF CLIENTS ACCEPTED FOR MOBILITY TRAINING

	Age			
Sex	16 - 25	26 - 50	Over 50	Total
Male	5	5	4	14
Female	2	13	2	17
Total	7	18	6	31

Forty-two per cent of these clients were blind from birth and fifty-eight per cent adventitiously blinded. The average age at which the adventitiously blind had become blind was 35.7 years, and, on the average, these clients had been blind for approximately nine years. Seven of these clients had previous mobility instruction at the North Carolina Rehabilitation Center. Thirty-nine per cent of the participating client population were totally blind; sixty-one per cent had some vision.

TABLE III

TYPES OF BLIND CLIENTS SERVED

Clients Served	Congenital	Adventitiously	Total
Totally Blind	9	4	13
Legally Blind	3	15	18
Total	12	19	31

CLIENTS WHO RECEIVED MOBILITY INSTRUCTION:

The initial plan was to provide mobility instruction one and one-half hours on Monday, Wednesday, and Friday of the first week and on Tuesday and Thursday of the second week to alternate throughout the program. This was altered about half way through the program to provide instruction one hour each day until completion of the individual's program. The rationale for this alteration was that it would help the client progress through the program more easily because of his ability to learn and incorporate the technique involved. Understandably, the ability to do this would vary from individual to individual.

However, it was felt that by making the training session shorter and more frequent, all participating clients could possibly do better.

Regarding the lessons taken, the smallest number was two (2), and the highest number sixty-six (66). The average number of lessons taken was twenty-two (22).

Of those clients accepted for mobility training, twenty-one (21) were terminated by the Agency because it was felt that they had progressed as far as possible, four (4) were considered to have completed the training. One client was terminated for repeated failure to keep appointments. Ten (10) clients withdrew prior to completion of training because they felt they had gained as much as they needed.

The following table shows a disposition of the case at the time service to the client was interrupted.

TABLE IV

DISPOSITION OF CASE AND EXTENT OF SERVICES RECEIVED BY CLIENT

Disposition of Case	Number of Lessons							
	0-5	6-10	11-15	16-20	21-25	26-30	Over 30	Total
1 Terminated	3	1	3	3	2	3	6	21
2 Withdrew	1	3	0	1	1	3	1	10
Total	4	4	3	4	3	6	7	31

1. Agency Decision (Includes clients who completed training)
2. Client Decision

In line with this it is interesting to note the number of lessons taken by the entire population to achieve a certain level of independent travel performance. Table V shows this with home orientation representing the elementary phase of training and business representing the most complex, which included travel on elevators and escalators.

TABLE V

CLIENT PROGRESS THROUGH TRAINING COURSE
AND LESSONS NEEDED

PROGRESS	Number of Lessons							
	0-5	6-10	11-15	16-20	21-25	26-30	Over 30	Total
Home Orientation	4	3	1	1	2	1	1	13
Residential	0	1	1	3	0	3	3	11
Business	0	0	1	0	1	2	3	7
Total	4	4	3	4	3	6	7	31

Those clients who received some training were evaluated by the instructor as to their capability of independent travel upon the completion of the program. Most were considered to be capable of independent travel in residential areas which presupposed that the client was fully capable of independent mobility in his home and surrounding area. In our considerations of the progress of the individual clients, they had to be completely mobile in both residential and business areas before they received that rating. However, those in the home and surrounding areas included some who only took a small number of lessons. Most were at least able to travel independently in their home.

The following chart shows a distribution of clients and their success and travel ability after completion of their program.

CHART I

CLIENTS CAPABILITY AND DEGREE OF INDEPENDENT TRAVEL
AFTER COMPLETING MOBILITY TRAINING

Business Area

Residential Area

Home

CLIENTS WHO DID NOT TAKE MOBILITY TRAINING:

There were more clients who inquired about mobility and did not take it than there were who inquired and were accepted for mobility. A number of reasons were given for withdrawals and on some cases the client was rejected by the project staff based on the diagnostic information. (See Master Table II.)

REJECTIONS:

A very careful analysis of each case was made and, if at all possible, the client was approved for mobility training. Only in cases where it was evident that medical and/or psychological factors definitely precluded participation in the program was a client rejected on these grounds.

At times the client would progress through the intake process which frequently was necessarily time consuming and then decide not to take training. It was also evident by the case record material that the instructor felt some clients were not good candidates for mobility training because of a negative attitude and his recommendation was accepted by the project staff.

WITHDRAWALS:

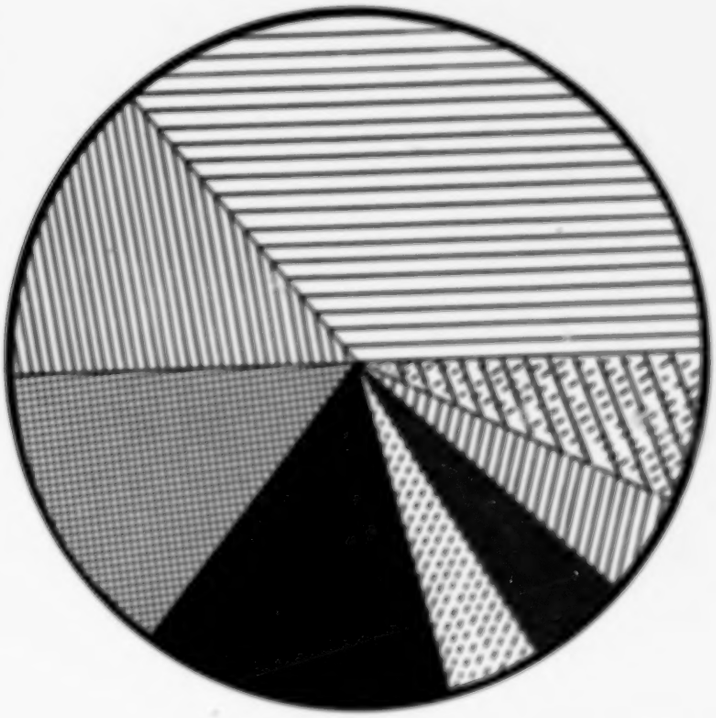
Most of the clients who inquired about training and did not participate withdrew following the initial interview. The program was fully explained to all persons who inquired about it. However, some did begin the evaluation process and withdrew at various times during the evaluative period.

Various reasons were given for not participating. Some stated they did not have time, family was against it, scared, or thought it was a good thing but wanted

to think about it. During the intake interview, an attempt was made to assess client interest and motivation. If these appeared to be low, it was felt by the project staff that it was best to let the client decide without anyone using any kind of pressure. However, an attempt was made to motivate the client by explaining the program fully and stressing the positive aspects of independent travel. Nonetheless, many clients did withdraw during the intake process, and the most common reason given was "not interested." The chart on the following page gives a breakdown of those clients who were rejected and who withdrew and the reasons presented.

CHART II

CLIENTS THAT DID NOT PARTICIPATE AND REASONS GIVEN



15	Client not interested.
6	Rejected - medical.
6	Pending - instructor resigned.
3	Satisfied with travel ability.
2	Did not have time.
2	Too fearful.
2	Family objected.
6	Other.

SURVEY:

The survey was used to gather information regarding mobility and motivation. As described earlier, the hypothesis was "Success in mobility enhances motivation to improve in other areas of social functioning." It was considered that a person was successful in taking mobility if he had completed training so that he could travel independently in residential areas.

Social functioning is defined as "those areas of everyday life encompassing all work and play situations." For example, if a client, after taking training, was able to travel independently to the corner grocery, then we felt this was an improvement in social functioning. Also, if a client traveled to work independently, this was considered an improvement in social functioning.

The areas included in the survey were: problems and services; duration and frequency of contact with the Peripatologist; cause of termination and nature of procedure; evaluation of program; feelings about evaluation process; present status of travel; diversity and frequency of social contacts; areas of increased motivation; and, evaluation of the interview.

The three areas felt most significant for this report are: areas of increased motivation; diversity and frequency of contact with the peripatologist; and feelings about the evaluation process.

It is felt that areas of increased motivation relates directly to mobility and motivation. Duration and frequency of contact was valuable in assessing one of the major project alterations, that is, length of lesson and frequency.

The information obtained relative to the evaluation process was important to gain some idea of whether the evaluative period was too time consuming, thus causing lack of interest on the client's part.

AREAS OF INCREASED MOTIVATION:

In order to test our hypothesis, "Success in mobility enhances motivation to improve in other areas of social functioning," it was felt that the client's responses in areas of increased motivation could be tabulated and categorized as increased motivation because of mobility, no increase in motivation, and unknown. Used as a measurement of success in mobility were those clients who had completed the residential and business phases of the training course. These two variables were cross tabulated and it was found that a majority of successful clients had improved in other areas of social functioning. In contrast, a majority of those clients who were unsuccessful in mobility did not improve in other areas of social functioning. This information, thus, indicates that success in mobility does enhance motivation to improve in other areas of social functioning. The following table shows this cross tabulation.

TABLE VI

CROSS-TABULATION OF THOSE CLIENTS WHO COMPLETED RESIDENTIAL AND BUSINESS PHASES OF THE PROGRAM TO IMPROVEMENT IN SOCIAL FUNCTIONING

	Improved	Not Improved	Unknown
Successful	10	3	4
Not Successful	5	1	7

DURATION AND FREQUENCY OF CONTACT WITH THE PERIPATOLOGIST AND THE EVALUATION PROCESS:

These sections dealt with the program alteration which decreased the lesson time but increased the frequency. Of those clients who responded to the question of diversity and frequency of contact, almost seventy per cent felt that lessons given one hour each day was more advantageous than lessons given one and one-half hours every other day. The most frequent response indicated that the client was better able to assimilate the material.

Throughout the project we were considering the effect that the rather long evaluation period had on client motivation and participation. The evaluation procedure as described earlier gave the client freedom of choice in the selection of physician. The caseworker provided transportation when needed. At times it was felt it would have been better to arrange all examinations so they could be completed in one or two days so as to speed up the process.

Of those clients who responded in this area, almost seventy-five per cent were satisfied with the evaluation process in spite of the length of time taken before mobility instruction could begin.

CHAPTER VI

DISCUSSION AND IMPLICATIONS

The purposes of this project were to provide mobility instruction to as many people as possible, gather information regarding mobility and motivation, and demonstrate to the community the need for mobility instruction.

The program came short of serving as many persons as was indicated in the original proposal, which was around one hundred (100). Approximately one-third of that number were served, and of our total population of seventy-three (73), less than half took mobility training. This could indicate that the original estimate was too high, as it would have involved around two hundred and fifty (250) clients in order to train one hundred (100), if the approximate same ratio of rejections and withdrawals prevailed. On the other hand, there were slack periods when the mobility instructor had only one or two clients with whom to work. During the spring and summer months he had a full case load (six) with a waiting list. However, during the fall and winter months, he had less clients and at times only one or two. This seeming pattern of lack of clients during adverse weather could indicate that the clients did not have a high degree of motivation.

The number of persons who withdrew and gave as their reason "not interested" indicates that client motivation to take the program was low. Most of the clients who inquired but did not take any training, and those who took some training and withdrew, were dependent public assistance clients. Also, very

few public assistance clients progressed beyond home and surrounding area in achievement. Conversely, mobility clients who did not receive public assistance had more success and fewer withdrawals. Employed clients who completed training in residential and business areas had the highest degree of motivational improvement. This indicates that the highly motivated client is likely to succeed in mobility.

The hypothesis of the survey was proved to some extent as indicated in the previous chapter because of the high number of people who succeeded in mobility and consequently improved in other areas of social functioning. Conversely, a large number of those clients who did not succeed in mobility later reported no improvement in other areas of social functioning.

Therefore, it is indicated that clients who succeeded in mobility were motivated to improve their social functioning. It appears that success in mobility led to emotional growth which helped the client to broaden their social experiences.

The final objective of this demonstration project was to demonstrate to the community and other agencies the need for professional mobility services. It is felt that a fair amount of success was achieved in this area.

Throughout the project various materials were developed to help demonstrate the need of professional mobility services. The inability to provide mobility service to the school children in the Charlotte-Mecklenburg Public School System prompted us to conduct a series of three mobility seminars for interested

parents and teachers. These seminars were conducted one evening per week for three successive weeks, during which time mobility training was thoroughly discussed. The prevailing attitudes toward independent travel and the use of a cane were explored and general training demonstrations were given. These seminars were felt to be highly successful and a booklet entitled "The Freedom of Movement for Blind Children", designed to assist teachers and parents, was developed. In addition, an article entitled "Orientation and Mobility Seminars for Parents and Teachers of Blind Children" was published in the New Outlook in an attempt to disseminate the information. A second article entitled "Peripatology in Practice" was also published in The Outlook and contained the highlights of a speech presented by the mobility instructor to the North Carolina Association of Workers for the Blind at their annual convention.

The Department of Public Welfare and the North Carolina State Commission for the Blind personnel had an opportunity to work with the project and became acquainted with professional mobility instruction and the degree of independence it provided the well trained individual. It appears that the need for professional mobility services was certainly recognized by this Agency, that is, the State Commission for the Blind, as indicated by the large number of referrals for mobility training.

The community in general was made aware of the professional mobility services at the MAB by the use of news media and on occasion a referral was received from another social agency. Other agencies in the Southeast inquired about the mobility program at the MAB and subsequently began mobility programs of their own.

CHAPTER VII

SUMMARY, CONCLUSIONS, and RECOMMENDATIONS

The MAB began a professional mobility program in June, 1963, under the auspices of the Vocational Rehabilitation Administration. This program was designed to demonstrate the value of mobility instruction as a technique to motivate blind individuals. The primary purposes were:

1. To provide mobility instruction to as many people as possible.
2. To gather information regarding mobility and motivation.
3. To demonstrate to the community the need for mobility service.

Seventy-three (73) clients inquired about the program, and thirty-one (31) took mobility training. Eighteen (18) of these, upon completion of their training, could travel independently in at least a residential area. Seven (7) of these could travel independently in business areas. Thirteen (13) did not progress to the point where they could travel independently in a residential area. A client was considered successful if he could travel in a residential area.

The majority of clients who inquired and did not take mobility gave as their reason for not participating as "not interested." This was interpreted as indicating a lack of motivation. The majority of those clients who took mobility training and were successful were motivated to improve in other areas of social functioning. On the other hand, the majority of those persons who were not

successful in mobility did not improve their social functioning.

It is felt that the mobility program was partially successful in attaining its stated objectives. As many people as anticipated were not served over the three years period primarily because of lack of client motivation and physical and mental limitations which precluded mobility training.

A great deal of information regarding mobility and motivation was secured by the case records and the survey. It was found that the highly motivated client is more apt to complete mobility and the clients who were successful in mobility showed a high degree of motivation to succeed in other areas of social functioning. Regarding demonstrating to the community the need for professional mobility instruction, it was hoped that the attainment of the first and second objectives would be the best way to meet the third objective. Therefore, partial success in this objective is indicated by partial success in the first two objectives.

The majority of clients who inquired did not take mobility training, and it is felt that there are many more potential clients in the Charlotte-Mecklenburg area that did not inquire. Based on the conclusions, the primary recommendation is that a research project be conducted to further study the lack of client motivation as regards mobility.

APPENDICES

APPENDIX

A

MECKLENBURG ASSOCIATION FOR THE BLIND

704 LOUISE AVENUE

CHARLOTTE, N. C.

NAME: _____ DATE: _____

AGE: _____ PERIPATOLOGIST: _____

Month	Day	Lesson

Month	Day	Lesson

Month	Day	Lesson

Month	Day	Lesson

MECKLENBURG ASSOCIATION FOR THE BLIND

MOBILITY SCALE

NAME:_____ DATE:_____

AGE:_____ PERIPATOLOGIST:_____

_____ DOES NOT TRAVEL ALONE _____

_____ TRAVELS ALONE IN HOME _____

_____ TRAVELS ALONE IN AND AROUND HOME _____

_____ TRAVELS ALONE IN FAMILIAR PLACES ONLY _____

_____ TRAVELS IN UNFAMILIAR PLACES _____

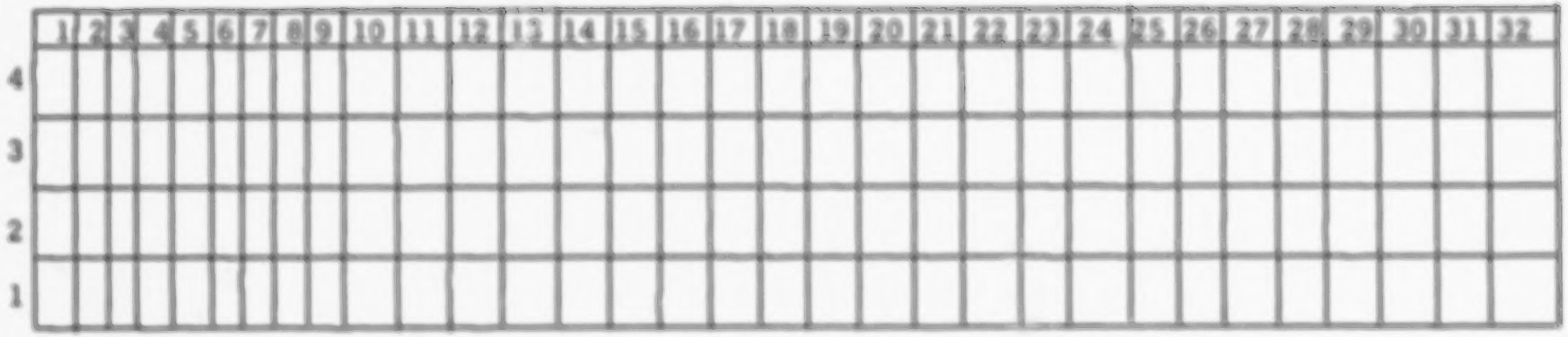
_____ TRAVELS IN UNFAMILIAR PLACES DOWNTOWN _____

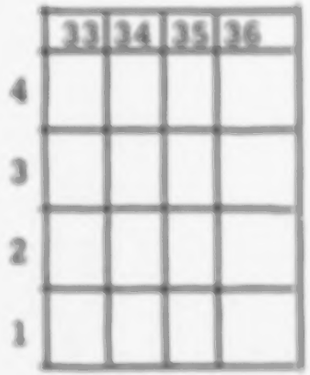
METHOD(S) OF TRAVEL:_____

PREVIOUS TRAVEL TRAINING:

RECOMMENDATIONS:

GRADE SCALE
Lesson:





EXCELLENT = 4

GOOD = 3

AVERAGE = 2

POOR = 1

RESTRICTIONS:

COMMENTS:

_____

PERIPATOLOGIST

APPENDIX

B

REPORT OF MOBILITY CLIENTS - AUGUST, 1963 - APRIL, 1966

Case No.	Source of Referral	Sex	Age	Visual Acuity	Age at Onset of Blindness	Education	Living Arrangements	Previous Training	No. of Lessons	Date Completed
2035	Self	M	52	Blind	2	Music-State School	Mother & married sister	Cane, Self-instructed	31	11/26/63
223	DPW	F	40	15/200-O.D. 1/200 - O.S.	Birth	State School	Lives Alone	White Cane	2	8/15/63
5242	Self	F	22	20/100-O.D. 20/100-O.S.		State School Rehab. Center	Lives Alone	100 Lessons at Rehab. Center	2	8/14/63
5204	Self	F	41	Blind	38	10th Grade	Lives with husband & Mother	None	30	2/07/64
5243	Self	F	26	L.P.	18	10th Grade	Lives with mother	None	4	10/28/63
5255	Self	M	66	L.P.QU.	64		Lives with wife	None	5	11/12/63
5268	Self	F	54	L.P.O.U.	Birth	6 mos. Grad. Casework U.N.C.	Lives with husband	None	35	11/27/63
5270	Self	F	44	L.P.O.D. Bi.O.S.	39	Business School	Lives with husband	None	11	10/24/63

Case No.	Source of Referral	Sex	Age	Visual Acuity	Age at Onset of Blindness	Education	Living Arrangements	Previous Training	No. of Lessons	Date Completed
5288	Self	F	41	L.P.O.D H.M.O.S.	20	5th grade	Lives with room-mate	120 Lessons Rehab. Center	8	2/07/64
4842	DPW	F	38	L.P.O.D. Total O.S.		9th grade	Lives with husband	100 Lessons Rehab. Center	6	12/20/63
4875	Self	M	49	Blind	44	9th grade	Lives with wife	None	23	11/14/63
5275	Self	F	50	H.M.O.U.	48	12th grade	Lives with husband	None	33	3/27/64
5075	Self	F	33	L.P.O.U.	Congen-tal	State School	Lives alone	60 lessons Rehab. Center	29	1/02/64
5311	DPW	M	49	L.P. - O.D. Blind - O. S.	46	10th grade	Lives alone	112 lessons at Rehab. Center	20	9/14/64
1785A	DPW	M	52	Blind	Birth	4th grade	Lives Alone	Self-instructed	7	8/18/64
4727	Self	F	70	Blind	Birth	Graduated State School	Metho-dist Home	Self-instructed	15	5/27/64

Case No.	Source of Referral	Sex	Age	Visual Acuity	Age at Onset of Blindness	Education	Living Arrangements	Previous Training	No. of Lessons	Date Completed
5326	State Com.	M	21	Bl.- O.D. H.M.-O.S.	20	Unknown	Lives with wife & family	None	27	12/4/64
3862	Family	M	12	Blind	Birth	In 7th Grade	Family	None	14	9/1/64
5308	Self	F	46	L.P.- O.D. 20/200- O.S.	Difficulty since Birth	12th Grade	Husband & Family	None	16	9/18/64
5417	Self	M	22	L.P.- O.U.	16	10th Grade	Lives alone	100 lessons at Rehab. Center	30	10/26/64
5339	Self	F	31	Blind	Birth	2nd yr. Graduate Student	Lives alone	None	24	10/27/64
5303	Self	F	28	Blind	Birth	6 mos. Graduate School	Room-mate	None	29	9/14/64
5334	Self	M	16	Blind	Birth	10th Grade Public School	Family	None	66	5/13/65
2534	Self	M	19	Blind	Birth	12th Grade Public School	Family	None	20	4/15/66

Case No.	Source of Referral	Sex	Age	Visual Acuity	Age at Onset of Blindness	Education	Living Arrangements	Previous Training	No. of Lessons	Date Completed
1017	State Com.	M	49	L.P.-O.U.	31	6th Grade	Wife & Family	Unknown	9	9/30/65
5406	Family	M	55	Blind 20/200 L	52	Masters Degree Pub. Health	Alone	None	25	4/4/66
4664	Self	F	35	Blind	?	8th Grade	Alone	Some at N.C. Rehab. Center	29	8/24/65
5361	Self	F	17	Blind	Birth	10th Grade	With Family	None	33	7/30/65
5339	Self	F	33	Blind	Birth	MSW-U.N.C.	Alone	MAB - 24 lessons	19	7/30/65
5349	DPW	M	34	Blind-R L.P.-L.	30	7th Grade	Wife & Family	None	54	7/28/65
5355	Memorial Hosp	M	48	Blind	48	2nd Grade	Roomer	None	32	7/19/65

APPENDIX
C

INDIVIDUALS WHO INQUIRED BUT DID NOT TAKE MOBILITY TRAINING
(Includes Rejections and Withdrewals)

Case No.	Reason for not participating
5359	Wasn't interested when interviewed. Indicated reconsideration at later date.
5144	Wasn't interested when interviewed. Indicated reconsideration at later date.
5364	Advanced diabetic - precluded mobility training.
5371	Had previous training which client felt was sufficient.
4111	Client felt she did not need mobility at this time.
5362	Client did not have time.
5070	Application pending when instructor resigned.
5407	Client was interested but did not have time.
3476	Application pending when instructor resigned.
?	Client was not interested.
4322	Client was not interested.
5351	Peripatologists felt client could not benefit from program.
4642	Application pending when instructor resigned.
152	Emotional state precluded mobility training.
5398	Emotional state precluded mobility training.
5306	Emotional state precluded mobility training.
3135	Project staff rejected because of client's immaturity.
2199	Client had feelings about using cane.
178	Rejected by staff because of lack of interest.
1461	Client not interested.
5227	Medical condition precluded training.
1312	Client not interested.
932	Application pending when instructor resigned.
457	Client was not interested.
5356	Client was not interested.
2955	Client felt he could see well enough and did not need training.

(cont'd)

Case No.	Reason for not participating
2955	Client could not "get up enough nerve".
5356	Client was not interested.
5285	Hearing difficulty precluded mobility training.
4151	Client not interested.
5401	Application pending when instructor resigned.
5376	Client interested but too fearful to try.
4612	Client not interested.
2	Client decided we could not teach him anything he didn't already know.
5327	Client not interested.
5316	Instructor felt client not feasible.
5263	Family objected to her carrying and using a cane.
2213	Family objected. Did not want her to use a cane.
5283	Client not interested.
5305	Client felt mobility training was unnecessary.
3504	Application pending when instructor resigned.
1944	Client not interested.

APPENDIX

D

SURVEY OF EX-CLIENTS OF MOBILITY

Date Recorded_____ Interviewer's Name_____

Respondent's Initials_____ Date of Interview_____ __ Race_____
Sex_____

Position in family_____ Other family members participating
(by status)_____

Total length of contact with Agency (approx.) months_____

A. Evaluation only.

SPECIAL OBSTACLES TO INTERVIEW_____

(indicate deafness, retardation if any)_____

Length of interview_____Minutes

RESPONDENT'S INITIALS AND INTERVIEWER'S NAME MUST APPEAR ON EVERY SHEET: SOME ENTRY MUST BE RECORDED ON EVERY SHEET: IF NO DATA, RECORD ACCORDINGLY. DO NOT LEAVE BLANKS.

Respondent's Initials_____ Interviewer_____

A. PROBLEMS AND SERVICES REPORTED

1. Problems
2. Services

B. DURATION AND FREQUENCY OF CONTACT WITH PERIPATOLOGIST

C. CAUSE OF TERMINATION AND NATURE OF PROCEDURE

D. EVALUATION OF PROGRAM

E. FEELINGS ABOUT EVALUATION PROCESS

F. PRESENT STATUS OF TRAVEL

G. DIVERSITY AND FREQUENCY OF SOCIAL CONTACTS

H. AREAS OF INCREASED MOTIVATION

I. EVALUATION OF INTERVIEW

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